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farin group and normal dose Warfarin group was kept between 1.5–2.0 and 2.1–2.5, respectively, in the perioperative period. Events regarding bleeding and thromboembolism were observed in both groups.

Results: Out of 31, none of the patient underwent any thromboembolic phenomenon. Among low dose Warfarin group, one patient presented three times with gingival bleeding. His INR at each bleeding time was 1.9, 1.85 and 2.0, respectively. No bleeding occurred after keeping the INR between 1.5 and 1.8. Five patients presented with gingival bleeding and nasal hemorrhage in normal Warfarin group. One patient with severe nasal bleeding (INR 2.4) and bleeding suspension after specialist to deal with and stop warfarin. No bleeding events after keep INR 1.7–2.1.

Conclusion: Warfarin anticoagulation in perioperative of 65–75 years old patients with atrial fibrillation catheter ablation while keeping the INR 1.5–2.0 is safe and effective.

Tracks: Electrophysiology.

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SHA 52. Glomerular filtration and the prevelance of atrial fibrillation recurrence after pulmonary vein isolation

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Objectives: Angiotensin II exerts proinflammatory effects leading to atrial fibrosis, a common finding in atrial fibrillation (AF). Rennin–Angiotensin system in kidneys and glomerular filtration are interconnected. Recently it has been proven that the prevalence of AF gradually increases with decreasing glomerular filtration rate (GFR). However, this study aim was to evaluate, whether the decreasing GFR influences the outcome of pulmonary vein isolation for AF or not.

Methods: The study was conducted at the Cardiology Department, Rawalpindi Medical College allied hospital from January 2009 to August 2009. One hundred and seventy-six consecutive patients with paroxysmal AF underwent pulmonary vein isolation. The relationships between GFR and ablation results were evaluated.

Results: The estimated GFR (eGFR) was lower in patients with recurrent AF after pulmonary vein isolation (PVI) compared to those without recurrence (71.1 ± 20.8 vs. 80.1 ± 16.1 ml/min/1.73 m^2, p60 ml/min/1.73 m^2). Clinical factors that were identified as a independent predictors of recurrence after PVI in this analysis were the decreasing GFR (hazard ratio: 0.97; 95%, CI 0.95–0.99, $P < 0.008$).

Conclusion: Enlarged LA diameter and decreasing GFR strongly influenced on atrial fibrillation recurrence after pulmonary vein isolation.

Tracks: Electrophysiology.

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SHA 53. Importance of septal site in right ventricular pacing among Pakistani Asian cardiac patients

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Objectives: Right ventricular septal pacing (RVSP) result in narrower paced QRS duration (p-QRS) than right ventricular apex pacing (RVAP) and prevention of worsening heart failure in patients with pacemaker implantation. Study aim was to identify the right ventricular pacing site with shortest p-QRS and determine whether all patients had narrower p-QRS pacing site.

Methods: Right ventriculography and pacing studies were done among 50 patients (33 male, mean age 67 ± 12 years). Right ventricle was arbitrarily divided into five sections (high right ventricular outflow tract RVOT, low RVOT, middle septum, low septum and apex) and estimated p-QRS during pacing (80 ppm) at each site. The superior margin of the RVOT was chosen as the pulmonary valve and the inferior margin was considered to be at the level of the HIS bundle. RVOT was divided into two equal parts. The area from the level of the HIS bundle to the base of the RV was divided in to two equal parts. The upper part was determined to be middle septum and inferior part was determined to be the low septum.

Results: p-QRS in the RVA was 167 ± 18 ms, while p-QRS in the low RVOT and middle septum was 143 ± 17 ms and 151 ± 20 ms, respectively. However, p-QRS in the low RVOT and middle septum were equal or longer than in the RVA in 16 patients (no effective group). There was no significant difference of LVDd, LVEF, LAD, and BNP between no effective group and other groups.

Conclusion: Right ventricular pacing sites with the shortest p-QRS were the low RVOT or middle septum. Almost 30% of our patients may not need special site pacing.

Tracks: Electrophysiology.

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SHA 54. Generator exchange of implantable cardiac device and patient restrictions over driving: A cohort study

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Objectives: In many countries motor vehicle driving is restricted for patients with an implantable cardioverter defibrillator (ICD). They are advised to avoid driving for a week or months after an ICD generator exchange (GEx). However, there is no evidence which demonstrates increase in ICD discharges (ICD-d) after a GEx. Study aim was to investigate whether this restriction is appropriate or not. ICD-d was checked before and after GEx.

Methods: This cohort study was carried out at Cardiology Department of Rawalpindi Medical College Hospital from January 2009 to July 2009. Among cohort of 446 patients with ICD, 89 patients who underwent a GEx (aged 52.6 ± 14.7 years, male 71) were reviewed and compared with the occurrence of the ICD-d in a 6-month period before and after the GEx. Also the incidence of ICD-d in 6 months after GEx between patients with an ICD-d before GEx and those without was evaluated.

Results: There was no significant difference in the occurrence of ICD-d in the 6 month period before and after the GEx in all of the 89 patients ($p = 0.12$). Moreover, patients without ICD-d before the GEx had significantly fewer episodes than those with ICD-d ($p = 0.01$).